EXPANDED COMMUNITY BASED DISTRIBUTION (CBD) PROGRAMME

2001 BASELINE SURVEY RESULTS

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FOREWORD

The Zimbabwe National Family Planning Council (ZNFPC) in collaboration with key stakeholders launched a project, in 1999, to review and redirect the ZNFPC Community Based Distribution (CBD) program to ensure that it remains cost effective and sustainable. A formative research study to assess the CBD programme was conducted and a report on the study was produced. The findings were disseminated to policy makers, planners, programme managers and programme implementers who then came up with recommendations for the CBD programme. The study findings and recommendations were utilised to make some programmatic changes to the CBD programme.

The key recommendations included implementing alternative models to the traditional door to door CBD approach and providing STI/HIV/AIDS and other selected reproductive health services through the CBD programme. The models are being piloted in selected districts. A monitoring and evaluation system for tracking progress has been put in place to monitor the project's performance. Implementation strategies for the alternative models will be adjusted as required. The CBD alternative models will be assessed to show results achieved by the end of the project. The Expanded CBD baseline survey has, therefore, been conducted to ensure that the impact of the redirected CBD programme will be assessed.

ZNFPC would like to take this opportunity to sincerely thank the Ministry of Health and Child Welfare (MOH & CW), United States Agency for International Development (USAID), Advance Africa (AA) and Population Council for the financial and technical support rendered during the different stages of the project.

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EXECUTIVE SUMMARY

Introduction

The family planning programme in Zimbabwe began in 1953 in urban and peri-urban areas. The adoption of the primary health care approach by the Government of Zimbabwe saw a strengthening of preventive health care systems. Access to family planning services was improved through the recruitment of over 600 Community Based Distributors (CBDs). The CBD programme has, among other achievements, contributed to the acceptance of family planning and the adoption of small family norms, especially in rural areas.

In view of the devastating impact of the HIV/AIDS epidemic in Zimbabwe, where prevalence is estimated to be 25%, and following the 1999 CBD Review Study, ZNFPC with technical assistance and funding from USAID through AdvanceAfrica, initiated the expansion of the roles of CBDs beyond the provision of family planning information and services. The major objectives of expanding CBD roles include increasing knowledge about STIs / HIV / AIDS and prevention among community members, outreach to young people whom CBDs used to exclude before, motivating those at-risk for voluntary counselling and testing, providing supportive counselling to both the infected and the affected and promoting the adoption of safer sexual behaviour.

CBDs in the project pilot sites underwent a two-week training course to strengthen their skills in the provision of the expanded services through two community-based models. The first model, the depot holder model, required the recruitment and training of depot holders who would supply oral contraceptives and condoms, thus enabling the CBDs to spend more time providing other services besides family planning. The second model, referred to as the satellite model, required the CBD to be stationed at a pre-arranged location in her catchment area on specified days so that clients come for services as opposed to the CBD providing door-to-door services. Sites selected for the depot holder model were densely populated while those selected for the satellite model were sparsely populated. In both models, the CBD's coverage area is a ward, usually made up of six villages with an estimated population of six thousand people.

All eight provinces selected one district to pilot one of the models, but to limit survey costs, the baseline study was conducted in six areas where the depot holder model, satellite model and a combination model were to be piloted. Two sites where the door-to-door model was still operating were included in the baseline survey as comparison areas. The baseline survey focused on young men and women aged 15 to 29 years. Information was collected from 1,812 respondents on their knowledge about transmission and prevention of STIs and HIV/AIDS; utilization of VCT services; utilization of contraception; use of condoms for infection prevention and contraception; and sexual behaviour relating to high risk.

Findings and recommendations

Youth's sexual experience and behaviour and the role of CBDs and DHs

Sixty nine (69) percent of female respondents and 66 percent of male respondents had ever had sex. The percentage of females who had ever had sex ranged from 45 percent in Zvishavane district to 82 percent in Bulilimamangwe district while that of male respondents ranged from 41 percent in Zvishavane district to 83 percent in Makoni district.

The average age at which respondents experienced their first sexual intercourse was 17 and 18 years for males and females respectively. This is the time when youths are likely to be in secondary school. Almost half (48 percent) of males and almost a quarter (22 percent) of females had their first sexual intercourse below the age of 16 years.

Fouty (40) percent of males and 8 percent of females have had sexual intercourse with at least two people during the twelve months preceding the survey.

Fifty six (56) percent of never married males and 63 percent of never married females reported being sexually experienced. Most females, 68 percent, said that their husband was their last sexual partner, while most males, 61 percent, reported that their last sexual partner was their fiancé/girlfriend. Occasional partners, rape and strangers were infrequently mentioned.

Recommendation: These findings confirm the need for CBDs and Depot Holders (DHs) to provide information to young unmarried people in their communities so that they make informed decisions pertaining to sexual activity and protect themselves from contracting STIs, including HIV / AIDS. CBD and DH efforts should be reinforced by information and education in schools and in the mass media.

Recommendation: CBDs and DHs, in their interaction with young people, should encourage abstinence and delay of sexual debut among those with no sexual experience. Among the sexually experienced, CBDs and DHs should emphasise the need to limit the number of one's sexual partners and use protection consistently and correctly, thus reducing the risk of contracting HIV.

Youth's use of family planning methods for contraception and infection prevention and the role of CBDs and DHs

Sixty one (61) percent of female youth and 65 percent of male youth were current users of contraception. Among these users, 74 percent of females were using the pill, and 16 percent were using the injectable. Seventy one (71) percent of males reported using condoms and 31 percent were relying on the use of the pill by their partners. Other methods were scarcely used, and knowledge about them was also low. Ministry of Health and Child Welfare (MOH&CW) clinics and CBDs were the most frequently mentioned current sources of modern FP methods for both sexes. CBDs tended to limit their discussions to the oral contraceptives and condoms that they distribute, and to the injectable that they can show but not provide.

Fifty three (53) percent of females and 65 percent of males used a method during the last sexual intercourse. The main method was the male condom (71 percent) for males and the pill (61 percent) for females. Injectables were also mentioned by females but less frequently. Forty percent of women used a method to prevent pregnancy compared to 28 percent of men. The percentage of those who used a method to prevent both pregnancy and infection (i.e. dual protection) was 28 and 10 percent for men and women respectively.

Thirty five (35) percent of females and 40 percent of males got their current contraceptives from CBDs. The CBD was the most known extension worker at community level with 77 percent males reporting knowledge of CBDs and 67 percent female respondents doing the same. This finding shows that CBDs are known to youth.

Desire to get pregnant and unplanned sex were the two main reasons for not using a method during the last sexual intercourse. Females were more likely to report desire to conceive and males were more likely to report that no method was used because sex just happened or was not planned. Both sexes also mentioned refusal by partner or self to use a condom.

Recommendation: CBDs and DHs should increase knowledge and motivate use of other contraceptive methods in their catchment areas as a strategy to ensure clients are using methods appropriate to their needs and to maximize cost-effectiveness.

Recommendation: The expected method shift to be facilitated by referrals from the CBDs and DHs to the local clinic requires that clinic-based service providers are informed about the expanded CBD programme and are prepared with staffing and reliable supplies of long-term methods and injectables. This includes consistent supplies of injectables at rural health centres.

Recommendation: As a strategy to reduce the level of new HIV infections, CBDs and DHs are expected to promote dual protection among their clients by providing them with both oral contraceptives and condoms. CBDs and DHs should also equip clients with skills to successfully negotiate condom use with their sexual partners, discuss the danger of unplanned sexual intercourse, and the need to be prepared with condoms, since this was another reason for non-use. This is a target group for follow up to ensure that condom use is consistent and correct.

Youth's knowledge about STIs / HIV / AIDS and the role of CBDs and DHs

Almost all respondents of both sexes in all the surveyed sites had ever heard of sexually transmitted infections. Knowledge of HIV / AIDS was nearly universal for both sexes in all the sites. Except for a few respondents, both males and females in all sites know that there is no cure for AIDS. Knowledge of specific STIs other than HIV was limited to gonorrhoea and syphilis with more males than females tending to know about these diseases.

Having sex with a partner infected with HIV was the most frequently cited mode of HIV transmission with more males (78 percent) reporting the mode than females (64 percent). Having multiple sexual partners was the second most frequently mentioned mode of HIV transmission with women (34 percent) mentioning it more than men (23 percent).

The school was the most frequently mentioned source of HIV / AIDS information for both sexes in all the sites, even for those who were no longer at school. Friends / neighbours / relatives were the second most frequently mentioned source by male respondents followed by radio. Doctors and nurses were the second most frequently mentioned source by female respondents followed by friends / neighbours / relatives and then radio. CBDs were mentioned as a source of HIV / AIDS information by less than three percent of respondents in all sites, regardless of gender.

Recommendation: CBDs and DHs should play an active role in increasing knowledge about STIs in their communities to facilitate self-referral to the clinic for treatment. The ZNFPC provincial staff should ensure that STI drugs are available at the local clinics so that referrals by CBDs and DHs for STI management are successful.

Recommendation: The need for CBDs and DHs to increase knowledge about mother-to-child transmission, is highlighted by the less than 10 percent respondents, regardless of gender and site, who mentioned non-sexual modes of HIV transmission.

Recommendation: CBD and DH educational efforts should be complemented by mass media and in-school IEC, in order to reach the maximum number of people and in order to reinforce messages.

Youth's perception of HIV/AIDS risk and the role of CBDs and DHs

Most females (43 percent) perceived themselves as having no risk of contracting HIV/AIDS and 14 percent thought they were at low risk. Forty (40) percent of males felt they were at low risk of contracting HIV/AIDS and 22 percent said they did not have any risk. Major reasons mentioned by those who perceived themselves to have no or low risk were that they only had one partner and that they are not yet sexually active. Always using condoms, not injecting drugs, and trusting partner were the other reasons given for no or low risk perception.

The percentage of males (15 & 9 percent) and that of females (14 & 8 percent) who believed that they were at medium and high risk respectively, was almost the same.

Recommendation: Despite acknowledging some level of risk of contracting HIV, most respondents did not report use of condoms, an aspect that needs to be addressed by CBDs and DHs. Some self-reported high-risk youth are still not using condoms at all. CBD's group meetings and other outreach activities should target these youth.

Recommendation: Approximately one fifth of male respondents and one tenth of female respondents believed they were at low or no risk because they always use condoms. This is a target group for CBDs to follow up to ensure that condom use is consistent and correct.

Youth's utilisation of VCT and the role of CBDs and DHs

Thirteen percent of females in Gutu and Makoni had ever been tested for HIV, but in all other areas, the percent of males and females tested was below ten percent. However, between 69

and 82 percent of youth are willing to be tested for HIV, and almost all of them gave as a reason "to know my status."

The main reason why respondents of both sexes were not willing to be tested for HIV was fear of a positive result. This could be an indication of the need to educate individuals how to live positively after testing positive to HIV and communities to accept and support those living with HIV /AIDS. Thirty-two percent of males who felt there was no need for them to have an HIV test were sexually experienced - - 71 percent of these were still single, thus increasing their chance of having other pre-marital partners. Twenty-seven percent of females who felt there was no need for an HIV test were sexually experienced including 32 percent who were still single.

Sixty four (64) percent of females tested for VCT had been referred by doctors or nurses. Men, on the other hand, tend to respond to media such as radios and newspapers. The school, friends / neighbours / relatives and the radio were also mentioned as sources of referral for VCT. None of those who had had an HIV test had been referred by CBDs.

Recommendation: CBDs should include risks relating to serial monogamy in their discussions with young people and how this exposes them to the risk of contracting HIV.

Recommendation: In the expanded programme, CBDs and DHs will be referring for VCT. Where possible, CBD and DH efforts to refer individuals for VCT could be complemented by other media at local level. Since the high transport costs are likely to deter individuals / couples from travelling to the urban VCT sites, consideration could be given to link the programme pilot sites to VCT outreach services, provided by New Start Centres where demand is high enough.

Recommendation: With or without testing, CBDs and DHs should stress the importance of safe sexual behaviours. Concurrently with motivating youth to go for testing, CBDs need to educate individuals how to live positively after testing positive to HIV, and clients' families and communities need to be educated about accepting and caring for those who are living with HIV / AIDS.

Coverage, coordination and linkages in the expanded CBD programme

Although many respondents knew the CBDs, less than half of respondents (28 percent of female respondents and 26 percent of male respondents) in areas where CBDs operate reported that they have ever been visited by CBDs. Although the current door-to-door CBD model emphasises interpersonal communication between CBDs and their clients, CBDs are also expected to periodically conduct group meetings within their catchment areas. A maximum of 10 percent reported ever being addressed at a meeting by CBDs. About three quarters of CBDs discussed family planning during their group meetings. HIV/AIDS and STIs were also discussed to a lesser extent, but more so with male respondents. CBDs generally do not discuss issues relating to home-based care, VCT, and youth reproductive health issues.

Recommendation: Increasing coverage through the depot holders and satellite system is a major goal of the Expanded CBD Programme. The DHs and satellite system should give CBDs more time to increase coverage through group meetings.

Recommendation: In the Expanded CBD Programme, CBDs should be given IEC materials and encouraged to talk to youth about reproductive health issues.

Besides CBDs and DHs, youth were familiar with Village Health Workers, Peer Educators, Environmental Health Technicians, Village Community Workers and Chloroquine Depot Holders. This highlights the needs for extension workers' coordination meetings at village and ward levels, so that everyone can participate in the planning and implementation of HIV/ AIDS related activities. Other extension workers as well as community leaders need to be made aware of the new depot holders and the expanded CBD roles.

Recommendation: CBDs are expected to attend Ward and Village Development Committee meetings, where they can mobilise support for programme efforts. Advocacy and mobilisation activities, as well as efforts to strengthen linkages, must be an integral part of the expanded programme.

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CHAPTER 1: INTRODUCTION

1.1 Background

Family planning services were introduced in Zimbabwe in 1953. In 1965, the Family Planning Association (FPA) of Rhodesia was formed to synchronise all family planning activities in the country. The Community Based Distribution (CBD) programme was established in 1967 to provide safe, low cost and effective family planning services in both rural and urban areas using the door-to-door model. CBDs move from home to home in their catchment area, informing, educating and motivating men and women about family planning methods and services and providing pills to those who need them. The door-to-door approach was the ideal model, given the low contraceptive prevalence rate of about 10 percent. The number of CBDs was increased to 800 by the end of 1993 in an effort to increase coverage of rural areas.

The CBD program has made significant contributions to the overall contraceptive prevalence rate (CPR) in the country. The 1988 Zimbabwe Demographic and Health Survey (ZDHS) showed that 25 percent of users of modern family planning methods, mainly in rural areas, obtained their methods from CBDs. The proportion declined to 18 percent in 1994 and further to 6 percent in 1999. The decline in the CBD contribution to the contraceptive prevalence rate (CPR) is mainly due to the increase in the number of Ministry of Health and Child Welfare (MOH & CW) clinics since 1980, the shift by clients from short term family planning methods to long term methods and the increase in the number of organisations providing family planning services.

Situation analysis of the family planning programme in Zimbabwe in 1991 and 1996 showed that CBDs spent most of their time re-supplying established clients and very little time recruiting new FP clients. The reduction of "medical barriers" in 1994/5 allowed CBDs to issue a maximum of six cycles of oral contraceptives on each visit to established clients. This allowed CBDs to spend less time in contact with re-supply clients, thus creating time for CBDs to take on other functions.

The 1999 CBD Review Study highlighted the need for CBDs to broaden their role beyond family planning services and include the provision of information on STIs, including HIV/AIDS, referral to clinics for the management of STIs, motivating communities for VCT and referring individuals or couples to the nearest VCT centres, providing supportive counselling to clients on the home based care (HBC) programme, providing reproductive health (RH) information to young people and increasing male involvement / participation in RH issues. The 1999 CBD Review Study also highlighted the need to establish mechanisms to improve the supervision of CBDs at community level, strengthen the referral system and linkages between the CBD Programme and the Ministry of Health and Child Welfare (MOH&CW). The suggested expansion of CBD roles necessitated the review of the service statistics forms to facilitate the monitoring of the expanded roles of CBDs. The CBD Review Study also showed that CBDs' catchment areas were too vast and this resulted in CBDs using a substantial amount of their working hours cycling to their clients' homes.

1.2 Expanded CBD Programme design

To implement the recommendations of the CBD Review Study, an Expanded CBD Programme was designed. This programme includes a "Satellite Model" and a Depot Holder (DH) model. The Depot Holder Model was successfully tested in Makoni District of Manicaland Province in 1994. In both models, the CBD will cover a ward with an estimated population of 6,000 villagers. (Six villages with an estimated population of 1,000 each make up a ward.) The DH model will be implemented where population is relatively dense. There will be a CBD located in one village and supervising five DHs, one in each of the remaining five villages in each ward. The DHs will re-supply established FP clients and refer clients for problem management to the CBD and method switching to the local clinic. The CBD in the DH model will re-supply clients in her village, manage FP clients with method-related problems and refer complicated cases to the local clinic. In addition to providing family planning information and services, the CBD will be expected to spend more time educating communities, including youth, on HIV/AIDS/STIs, motivating communities for VCT and providing supportive counselling to clients on the home-based care programme.

The "satellite model" will be tested in areas where population is scattered. The CBD, also at ward level, will provide FP services at designated points in the ward on specific days. The CBD in this model will also be expected to provide the HIV/AIDS/STIs information and supportive counselling for the Home Based Care programme and motivate for Voluntary Counselling and Testing services.

CBDs in both models will be expected to play an active role in the village and ward level committee meetings and be active members of the clinic-based Health Committees. The involvement of CBDs in such committees will ensure that RH issues, including family planning and HIV/AIDS, are integrated into all activities planned and implemented at village and ward levels. CBDs in both models (DH and satellite) will be expected to conduct group talks to complement their one-to-one interactions with clients on wide-ranging issues related to reproductive health, with emphasis on HIV/AIDS. CBDs' skills in giving effective group talks will be strengthened prior to the implementation of their expanded roles.

1.3 Pilot implementation and collection of baseline data

Zimbabwe has ten provinces, including the two urban provinces of Harare and Bulawayo. The ZNFPC administrative structure works through the eight larger provinces of Manicaland, Mashonaland Central, Mashonaland East, Mashonaland West, Midlands, Matabeleland North, Matabeleland South, and Masvingo.[1] ZNFPC and MOH&CW staff in all the eight provinces selected two districts for piloting the expanded CBD programme. These selected districts were ones with access to a VCT referral centre and with ZNFPC administrative staffing in place, including trained and experienced CBDs and Group Leaders. (Prior experience in implementing new systems showed that new staff are not ideal for implementing new programmes, because they are still in the process of learning their basic jobs and gaining acceptance by the communities.). One district from each province was then selected for the first phase, first year, with the remaining districts to be included in the second phase, second

[1] Urban CBDs working in Harare and Bulawayo are not included in the expanded pilot programme.

year. The selection for the first phase, first year was based on administrative and logistic convenience, considering current budgetary constraints due to difficult economic circumstances in Zimbabwe.

Originally it was planned to carry out the baseline study in all eight of the programme implementation districts. Due to budgetary constraints, four districts, with five programme implementation sites, were selected at random for the baseline study. In addition, two comparison, or "control" areas were selected. The District site selections, with assignment of different models for the pilot period, are shown in Table 1.1.

Table 1.1 Pilot sites by Type of CBD pilot model, province and district

Province	Pilot District	Type of CBD model being piloted	Baseline data collected
1. Manicaland	Makoni North [2]	Depot Holder	Baseline
2. Manicaland	Makoni South	Depot Holder	Baseline
3. Mashonaland East	Marondera	Depot Holder + Satellite	Baseline
4. Matabeleland North	Umguza	Satellite	Baseline
5. Masvingo	Gutu	Depot Holder	Baseline
6. Matabeleland South	Bulilimamangwe	Door to door (old model), comparison area for satellite model	Baseline
7. Midlands	Zvishavane	Door to door (old model), comparison area for the depot holder model	Baseline
8. Mashonaland West	Zvimba	Depot Holder	No baseline
9. Matabeleland South	Umzingwane	Depot Holder	No baseline
10.Mashonaland Central	Bindura	Depot Holder	No baseline
11. Midlands	Chirumanzu	Depot Holder	No baseline

Experience during the pilot phase of the first Depot Holder model in Makoni District in 1994 showed that recruiting new CBDs to pilot test a model introduced too many variations into the pilot since quite a lot of their time was spent gaining community acceptance and learning how to function as CBDs. As a result, CBDs already working in the selected pilot areas, were chosen for training in the new system.

In preparation for the implementation of the pilot programme, the following activities took place:

- The baseline study reported in this document was carried out to establish current levels of service delivery, knowledge and practices relating to the reproductive health of young adults aged 15 to 29;

[2] Makoni is one district, but it was divided into two project sites because of the large coverage and number of CBDs there.

- The CBD and Group Leader (GL) training and procedure manuals were re-written to incorporate the new CBD roles;
- CBDs, Depot Holders (DHs) and GLs in the pilot districts underwent a 2-week re-orientation course to train them in their new roles.
- Trainees were all provided with demonstration kits (penile model, depo provera and syringe, oral contraceptives and condoms), checklists, manuals, oral contraceptives and condoms; client cards and register books, MIS forms, a cash box with inbuilt lock and a trunk and lock;
- GLs underwent a week long supervisors' course to strengthen their skills, especially the supervision of the expanded CBD roles;
- Site-specific, expanded CBD programme advocacy packages were formulated and advocacy workshops at community level were conducted to mobilise support;
- Depot Holders (DHs) were recruited with community participation;
- Recruited DHs were trained by ZNFPC provincial training teams;
- IEC support materials were produced for CBDs and GLs;
- Co-ordination meetings between the CBD programme and stakeholders were held to strengthen linkages between relevant sectors;
- The referral forms for use between the CBD programme and health centres, hospitals and VCT facilities were reviewed and improved;
- The DH and CBD service statistics forms were modified to monitor implementation and effects of the expanded programme; and
- ZNFPC appointed a CBD programme co-ordinator to oversee the implementation of the pilot programme.

The key issues that will be monitored during the pilot period include:

- Client referrals by CBDs for long term and permanent methods
- Referrals for VCT, STI / HIV/ AIDS, home based care
- The provision of youth information and services
- Male motivation
- The extent of co-ordination with other extension workers at community level
- Attendance of ward / village / ward health committee meetings aimed at improving co-ordination of programmes at community level.

1.4 Objectives of the Baseline Survey

The goal of the "Expanded CBD Baseline Survey" was to collect data that will be used as a benchmark in evaluating outcomes that the "Expanded CBD project" will have on the target population in the selected sites.

The specific objectives of the study are to provide baseline data on services offered by the CBDs and to provide information on the reproductive health knowledge, attitudes and behaviour of people aged 15 – 29 years, in both the experimental and comparison sites for the Expanded CBD project, prior to the implementation of the pilot programme in the eight pilot districts.

1.5 Monitoring and Evaluation Plan

A comprehensive monitoring and evaluation plan was prepared to provide evidence of project implementation, outputs, effects and outcomes. Six main tools are included:

- Routine collection of service statistics. Service statistics forms were modified to reflect the expanded roles of the CBDs and the new roles of the DHs. Statistics on VCT referrals will be collected both from the CBDs and from the VCT sites.
- Pre and post training tests to reflect new knowledge and skills acquired by those trained
- Follow up supervisory visits to assess practice of new knowledge, skills and responsibilities
- Initial Assessment to provide early guidance and feedback on the initial implementation of the programme
- A Mid Term Review /Assessment of the programme
- An impact evaluation (endline) survey and final evaluation will be conducted to measure changes over time and to compare the effects and outcomes of the three models.

1.6 Questionnaire design and content

Two questionnaires, one for males and the other for females, were designed to collect data on background characteristics of young adults aged 15 to 29; fertility; sexual experience and practices relating to high risk; family planning knowledge and practice; knowledge about STIs/HIV/AIDS; and CBD interaction with clients. The questionnaires were translated into the two major languages, Shona and Ndebele.

1.7 Sampling design

A district has an average of about 10 CBDs. In each of the six selected districts for the study, catchment areas for five of the ten CBDs were randomly selected for data collection. A total of 30 CBD catchment areas were, therefore, visited for the study. Twenty of the catchment areas are in experimental sites while 10 are in comparison sites.

In the Expanded CBD Programme, a CBD catchment area includes an average of six villages. Supervisors for the research teams identified and listed names of all the villages in the selected catchment areas. They then selected two adjacent villages for male interviews and another two adjacent villages for the female interviews in each catchment area.

The target sample size for the baseline survey from all the selected sites was 1,800 respondents aged 15 to 29. Sixty respondents (30 males and 30 females) were to be interviewed in each of

the selected CBD catchment areas. This meant that 300 respondents (150 males and 150 females) were to be interviewed in each selected district/site.[3]

1.8 Training and Fieldwork

Twelve research assistants and three supervisors were trained on how to conduct the survey from the 15th to 19th August 2001 at the ZNFPC Head Quarters. The 12 research assistants were mainly social science students and graduates from the University of Zimbabwe while the three supervisors were ZNFPC officers from provinces. Three teams composed of four research assistants and a supervisor, were formed at the end of the training. Each team covered two districts (10 CBD catchment areas). Three ZNFPC Head Office staff (Programme Manager Research, Acting Assistant Director Service Delivery Unit and Assistant Director IEC) each supervised a team during fieldwork. The fieldwork was undertaken from the 20th to 31st August 2001.

Male research assistants collected data from male respondents while female research assistants collected data from female respondents. All eligible persons in each sampled household were listed on the questionnaire and one person in the relevant age group was randomly selected from each household for the interview.

1.9 Data processing and analysis

Data entry was accomplished using the EPIINFO software package. Data processing and analysis commenced in October 2001. The analysis plan included descriptive and bivariate statistics. For data analysis, all the study sites were re-grouped into four study zones as follows:

Zone I:	Depot Holder model, *Makoni and Gutu districts*
Zone II:	Satellite model, *Umguza district*
Zone III:	A combination of the Depot Holder and Satellite models, *Marondera Rural district*
Zone IV:	Comparison area sites using old door-to-door model, *Bulilimamangwe and Zvishavane districts*

1.10 Limitations and strengths of the survey

The baseline study population included only males and females aged 15 to 29 years, because this is the prime target group for behaviour change. Sampling selection was not purely random. Purposive criteria included closeness to Provincial Management and availability of referral sites. The comparison areas were not statistically matched with the intervention areas in terms of population and programme characteristics. However, some of this can be controlled for in analysis, using the background characteristics of the study population.

[3] When the survey was conducted, political parties were holding rallies to campaign for a parliamentary seat in Makoni district. Due to the study's tight time schedule, the research team for Makoni had to interview some of the people who were at a political rally since there were no people in the households. This resulted in a few extra respondents for the survey, whose information was included in the analysis.

The field operations were well organized and the degree of supervision was adequate. Questionnaires were translated into local languages and research assistants proficient in the languages were employed.

CHAPTER 2: CHARACTERISTICS OF RESPONDENTS

2.1 Distribution of survey respondents by District

A total of 1,812 respondents aged 15 to 29 years who were residing in private households were interviewed for the study. Table 2.1 shows the distribution of survey respondents by district, CBD model and sex.

Table 2.1 Distribution of survey respondents by district: Expanded CBD Baseline Survey, August 2001

District/Site	CBD Model	Number of Respondents		
		Male	Female	Total
Makoni	Depot Holder	149	161	310
Gutu	Depot Holder	151	150	301
Marondera	Depot Holder & Satellite	159	143	302
Umguza	Satellite	149	151	300
Bulilimamangwe	Comparison – old model	150	151	301
Zvishavane	Comparison – old model	148	150	298
Total		906	906	1,812

2.2 Distribution of respondents by marital status

Information collected on marriage was on "current marital status". For the purpose of this study, "married" means either formally married or living together in a consensual union. The data on marriage provide an indicator of exposure to pregnancy. However, data on age at first sexual intercourse in Zimbabwe (Zimbabwe Demographic and Health Survey [ZDHS] 1999 & National Youth Reproductive Health survey [NYRHS] 1997) show that a considerable number of women report having sexual intercourse before their first marriage.

Most respondents in the baseline study were "never married". The proportion "married" is higher among females (41%) than among males (21%) while the proportion "never married" is higher among males (75%) than among females (49%). This is the case for all zones. The highest proportion of married respondents was in Zone III.

2.3 Distribution of respondents by age and education

The mean age of the respondents was 21 years. It ranged from 20 to 23 years for males and was 21 years for females in the four zones.

Schooling is a variable that is very clearly and directly associated with the level of contraceptive use in a population. Substantial evidence shows that educated girls, especially those who have completed secondary education, are less likely to marry young, to have an unwanted pregnancy and to engage in high risk behavior such as unsafe sex. Avoiding pregnancy enables girls to stay in school. Almost all respondents have attended school, and the

largest proportion (72 percent males and 70 percent females) had attended a secondary level of education.

2.4 Distribution of respondents by languages spoken and read

Information on modern contraceptive methods and prevention methods of STI/HIV/AIDS should be conveyed in the most spoken and read languages. The most spoken and read language by the respondents is Shona in Zones 1 and III and Ndebele in Zone II. In Zone IV, over half of male and female respondents read and speak either Shona or Ndebele. The proportion of males who can speak English is greater than that of females in all the four zones. Zone II has the least proportion of respondents who speak English followed by Zone IV. The proportion of females who can read English is double that of males in Zone II and IV.

2.5 Distribution of respondents by main activity

All respondents were asked about their main activity during the last 12 months before the survey. The findings indicate that most female respondents (42 percent) were homemakers followed by paid employees (27 percent). A homemaker is a person of either sex involved in household chores e.g. fetching water, cooking, baby sitting etc. and who does not work for pay or profit. There were no employers among the female respondents. This pattern was consistent for all women in all the four zones. About 1 in every 5 female (20 percent) respondents aged 15 – 19 years were students. The proportion of students declines to 2 percent among the 20 – 24 year old females and to 0 percent among the 25 – 29 year old females.

The majority of male respondents (35 percent) were paid employees followed by students (17 percent). The proportion of male respondents who were looking for work was four times that of female respondents (16 percent of male respondents reported that they were looking for work compared to 4 percent of females). Except for female respondents in Zone II and IV, more than half of male and female respondents in the other zones were engaged in activities which lead to the production of goods and services for income in cash and/or in kind.

2.6 Respondents' Main Source of Income

Students, homemakers, unpaid family workers and those who were looking for work were asked about their main source of income. Sixty one percent of males and 46 percent of females reported that "parents" were their main source of income. For males, "other family member(s)" was the second main source of income while "husband" was the second main source of income for females.

CHAPTER 3: PREGNANCY AND FERTILITY

In this chapter, data on pregnancy experience, average parities/children ever born and willingness to avoid pregnancy within the next 12 months after the survey is presented for the female population. Information about pregnancies and their outcomes (live births, abortions / miscarriages, stillbirths) was collected for each female respondent irrespective of marital status.[4]

3.1 Fertility of women aged 15-29 who have ever been pregnant

The following table shows the percentage of women who have ever been pregnant by number of live births.

Table 3.1 Distribution of women aged 15-29 who have ever been pregnant by the number of live births

Number of live births	Number of women	Percent of women
0	31	5.9
1 – 2	401	75.8
3 – 4	87	16.4
5 – 6	8	1.5
Missing	2	0.4
Total	529	100

Fifty eight percent of the female respondents have ever been pregnant while 42 percent have never been pregnant. Almost six percent of pregnancies did not end with live births. Among the 529 respondents who have been pregnant, 76 percent have had 1 -2 live births, 16 percent have had 3 -4 live births while about 2 percent have had 5 – 6 live births. The average number of live births in this group is 1.8. Considering the mean age of the studied group, this fertility rate seems high.

Table 3.2 Percent distribution of women who have ever given birth to a live baby by number of children ever born and by age group

Age group	Number of live births						Total	
	1	2	3	4	5	6	Percent	Women
15 - 19	94	4	-	-	-	-	100	70
20 –24	62	33	-	-	.5	.5	100	218
25 - 29	20	40	11	2	2	2	100	208
Total	49	32	13	4	1	1	100	496

[4] The "Expanded CBD Baseline Survey" collected information from women aged 15 to 29 years and, therefore, the TFR is not a relevant statistic. Also, the sample for the survey is not large enough to compute fertility measures by zone / site.

3.2 Desire of female respondents to avoid pregnancy

The percentage of women who want to avoid pregnancy within the next 12 months roughly indicates the current existing demand for family planning services. Table 3.3 shows the percent of women who want to avoid pregnancy within the next 12 months, by their marital status and by their age. Six percent of all female respondents were currently pregnant. Among those who were not pregnant (846 women), a large proportion (72 percent), regardless of their marital status and age, said they wanted to avoid pregnancy within the next 12 months. The younger the woman, the more likely she is to want to avoid pregnancy.

Table 3.3 Percentage of women who want to avoid pregnancy within the next 12 months by marital status and age group

Marital Status	Percent wanting to avoid pregnancy	Total number of respondents
Married, living with husband	65	243
Married, husband living away	62	81
Widow	92	24
Divorced/separated	83	72
Never married	75	426
Total number of respondents	72	846
Age group:		
15 – 19	77	344
20 – 24	69	298
25 – 29	68	204
Total	72	846

3.3 Average Parities

The information on the number of children ever born was used to provide a parity distribution for all respondents. The average parity for the survey respondents is shown in Table 3.4. The average parity increases with age with the 15 – 19 year olds having a parity of 0.2 children per woman while the 20-24 year olds and the 25 – 29 year olds have an average parity of 1 and 2 children per woman respectively.

Table 3.4 Distribution of women who have ever given birth by children ever borne and average parity by age group

Age Group	Number of Women	Children Ever Born	Average Parity
15 – 19	365	75	0.205
20 – 24	317	316	0.997
25 – 29	223	495	2.220
Total	905	886	

CHAPTER 4: CONTRACEPTIVE KNOWLEDGE AND USE

4.1 Knowledge of contraceptive methods

Respondents were asked whether they were aware of the various ways or methods that people use to delay or avoid pregnancy. The pill and the male condom were the most known methods with more women tending to know about pills, while more men were knowledgeable about male condoms. More women had heard of injectables, IUDs and Norplant compared to men. Table 4.1 shows that other methods, besides the pill and male condoms, were less frequently mentioned. CBDs should aim to increase people's knowledge of other contraceptive methods in their catchment areas as a strategy to widen the contraceptive method mix.

Table 4.1 Percent of 15-29 year old respondents who reported knowledge of specific contraceptives by zone

Contraceptive known	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison	
	M	F	M	F	M	F	M	F
Pill	67	81	55	80	85	81	45	76
IUD	9	18	7	25	12	24	7	19
Injectable	19	43	22	65	32	50	18	46
Norplant	1	6	1	13	1	6	1	6
Diaphragm	3	3	1	3	1	3	2	4
Male condom	76	46	76	39	87	46	60	40
Female condom	12	25	28	19	34	11	13	25
Tubal ligation	5	7	7	2	4	8	3	2
Vasectomy	4	4	5	3	4	0	4	1
Periodic abstinence	2	1	3	2	3	2	2	1
Other	0	3	5	3	0	3	1	3
Number of cases	300	311	149	150	158	143	298	301

Table 4.2 Percent of 15-29 year old respondents who received information on specific contraceptives from CBDs

Information received about:	Zone I Depot Holder		Zone 2 Satellite		Zone 3 Depot Holder & Satellite		Zone 4 Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Pill	18	17	12	42	20	9	6	10
IUD	4	10	0	2	7	6	4	3
Injectibles	10	10	8	5	6	4	3	5
Norplant	3	6	0	0	6	3	4	8
Male condom	12	11	7	5	6	12	4	6
Female condom	9	10	5	2	7	5	1	6
Tubal ligation	3	7	0	3	7	3	1	2
Vasectomy	3	5	0	2	6	3	1	2
Periodic abstinence	1	0	0	3	2	0	0	2

4.2 Sources of information on contraceptive methods

Doctors / nurses / clinics, schools, friends / neighbours / relatives, CBDs and sometimes the radio were the most frequently cited sources of information on specific contraceptives (see Table A4.1 in the Appendix). Schools were mentioned as sources even by out of school respondents. Table 4.2 shows the percent distribution of respondents who got information on specific methods of contraception from CBDs. The findings indicate that CBDs tend to limit their discussion to oral contraceptives, male condoms and injectables. A shift to other methods, especially injectables that are available at Rural Health Centre (RHC) level, will require more efforts by CBDs to motivate clients for contraceptives available at clinics.

4.3 Ever use of contraceptive methods

Table 4.3 shows that between 38 percent and 55 percent of women in all sites had ever used contraception compared to between 45 percent and 72 percent for men. Most of the men had ever used male condoms (range 77 – 96 percent) followed by the pill (14 – 43 percent). For women, most had ever used the pill (range 73 to 89 percent), injectables (16 – 34 percent) and male condoms (20 – 27 percent). Less than 5 percent of all respondents, regardless of gender, mentioned ever use of the female condom. Other methods were scarcely used.

Table 4.3 Percent distribution of 15-29 year old respondents reporting ever use of contraceptive methods and type of contraceptive ever used by zone

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Ever use of any method	55	51	48	55	72	55	45	38
Number of cases	300	300	149	149	158	159	298	298
Pill	35	89	19	74	43	89	14	73
IUD	2	1	0	0	1	1	0	1
Injectables	3	16	11	34	1	22	4	20
Norplant	0	0	0	1	0	1	0	0
Diaphragm	1	0	0	1	0	1	0	0
Male condom	87	27	90	24	77	27	96	20
Female condom	3	3	0	3	3	0	0	1
Tubal ligation	0	1	0	0	0	0	0	0
Vasectomy	0	0	0	0	0	0	0	0
Number of cases	164	160	72	82	113	79	135	115

4.4 Current use of contraceptive methods

Except for the comparison areas, which had 50 percent of women who were currently using family planning methods, the rest of the areas had between 62 and 67 percent of women who were currently using an FP method. Between 63 to 76 percent of men interviewed were using a method at the time of the survey (see Table 4.4). These contraceptive prevalence rates are higher than the 44 per cent national average for rural areas found in the 1999 ZDHS. This is likely to be because women in the surveyed areas can get contraceptive supplies from both clinics and CBDs.

At least sixty percent of men who were currently using a method were using male condoms (see Table 4.4). Most of the women were currently on the pill with proportions ranging between 62 percent and 82 percent in the zones surveyed. Between 11 percent and 29 percent of females were on injectables. The rest of the methods offered in the family planning programme such as diaphragms, Norplant and permanent methods were hardly used.

Table 4.4 Percent of 15-29 year old respondents reporting current use of contraceptives, percent reporting current use of specific types of contraceptives and percent sourcing current methods from CBDs

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Current use of any FP method	68	67	76	63	68	62	63	50
Number of cases	164	160	72	82	114	79	63	50
Pill	43	79	15	62	47	82	12	67
IUD	0	3	0	0	0	0	0	2
Injection	2	11	7	29	3	14	1	16
Norplant	0	0	0	0	0	0	0	0
Diaphragm	1	0	0	1	0	1	0	0
Male condom	61	5	80	10	60	8	88	16
Female condom	2	0	0	0	0	0	0	0
Tubal ligation	0	1	0	0	0	0	0	0
Vasectomy	0	3	0	0	0	0	0	2
Number of cases	111	107	55	52	77	49	85	57
Percent sourcing current contraceptives from CBD	44	51	33	15	53	29	29	28
Number of cases	110	107	55	52	77	49	85	57

4.5 Current sources of contraceptive methods

Table 4.4 shows the percentages of currently contracepting young men and women who are supplied by a CBD agent. Table A4.2 in the Appendix shows the percentage distribution by all sources. In all the areas, the MOH & CW clinics and CBDs were the most frequently mentioned current sources of modern FP methods, regardless of gender. Clinics are the most common source except for Zone I, and among men in Zone III (see Table A4.2). Except for the DH-Satellite model where 29 percent of females mentioned ZNFPC clinic as the current source, overall, less than 10 percent of respondents mentioned this source, and no one mentioned the ZNFPC clinic among the females in the comparison areas. This is probably because ZNFPC clinics are generally situated in provincial towns. Other community-based health workers were hardly mentioned as sources of FP methods.

Overall, 45 percent of female respondents on the pill got their supplies from CBDs compared to 41 percent who got them from MOH & CW clinics. Thirty-seven percent of females currently on the condom got their supplies from CBDs; 32 percent got them from MOH & CW clinics, while 22 percent got their condom supplies from shops.

CHAPTER 5: SEXUAL EXPERIENCE AND BEHAVIOUR

Evidence to date has shown that, in Zimbabwe, HIV is mostly transmitted heterosexually. The expanded CBD programme is aimed at influencing sexual behaviours that put people at risk of contracting HIV. In order to formulate appropriate interventions, respondents were asked a number of questions to find out when they became sexually experienced, their number of sexual partners and reasons for condom use.

5.1 Sexual experience of respondents and age at first sexual intercourse

Table 5.1 shows that between 64 and 79 percent of 15-29 year old females and between 64 and 80 percent of 15-29 year old males had ever had sexual intercourse. Young people in all zones tend to initiate sex between the ages of 15 and 19 years, a time when they are likely to be in secondary school. Nearly a quarter (23 percent) of males in Zone II initiated sex below the age of 15 years.

5.2 Number of sexual partners

Across all zones, females were more likely to have had one sexual partner in the preceding 12 months compared to their male counterparts (see Table 5.1). Between 86 and 96 percent of females in all regions had one sexual partner. Between four and fifteen percent of females had more than one sexual partner during the twelve months preceding the survey compared to between 37 and 63 percent of males. Between 37 and 63 percent of males in all zones had had one sexual partner. Zone II had the least proportion (37 percent) that had had one sexual partner followed by Zone III (57 percent). Zone II males tend to report more than one sexual partner compared to males in other zones.

5.3 Marital status of sexually experienced respondents

Among those who were sexually experienced, most women are ever married (the range is 57 to 91 percent), whereas except in Zone III, sexually experienced young men are more likely to be never married (Table 5.1). This could be due to several factors -- females marrying earlier than males, or underreporting by females of sexual experience. There were two zones – II and IV – where 43% of sexually experienced women were never married.

Table 5.1 Percent reporting sexual experience, age at first sex, number of sexual partners, marital status of sexually experienced respondents and relationship to last sexual partner.

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Ever had sex	64	67	71	79	80	74	56	64
Number of cases	300	311	147	150	158	142	298	301
Age at sexual debut								
< 15 years	9	5	23	3	11	1	15	6
15-19	64	63	65	82	57	88	69	75
20-24	24	30	12	15	31	11	15	17
25-29	3	1	0	0	0	0	2	1
Number of cases	192	208	103	115	126	105	165	191
Number of sexual partners in last 12 mos.								
1	63	96	37	86	57	96	59	90
2	17	3	18	8	21	1	17	8
3	8	1	12	6	11	1	17	1
4 and above	12	0	33	1	11	2	17	1
Number of cases	163	208	100	119	114	105	150	192
Marital status of those with sexual experience								
Ever married	42	91	24	57	60	88	21	57
Never married	58	9	76	43	40	12	79	43
Number of cases	193	208	104	119	125	105	168	192
Relationship to last sexual partner								
Spouse	34	84	18	50	50	83	14	53
Partner, co-habitee	3	1	7	4	3	1	1	0
Boyfriend, girlfriend	57	13	69	45	43	15	73	43
Occasional partner	4	1	2	1	3	0	7	1
Rape	0	0	0	0	1	1	0	0
Stranger, just met	2	1	0	0	0	0	1	0
Other	2	0	4	0	0	0	4	0
Number of cases	193	208	104	119	125	105	168	192

5.4 Relationship to last sexual partner

Females in all zones were much more likely to cite their husbands as their last sexual partners, whereas males tended to report girlfriends or fiancées as their last sexual partners (see Table 5.1). The exception for females was that in Zones II and IV, 43-45 percent of females did report that their last sexual partner was a boyfriend. Sex with occasional partners or with strangers was scarcely mentioned in any zone.

5.5 Use of FP methods during the last sexual intercourse

Table 5.2 shows that between 48 and 60 percent of females and between 45 and 60 percent of males used a method during the last sexual intercourse. The main method last used was the male condom for males and the pill for females (see Table 5.2). Less than 10 percent of females mentioned injectables, except in Zone II (23 percent) and Zone IV (14 percent). No mention was made of Norplant, diaphragm, tubal ligation and vasectomy, and 1 percent or less mentioned the female condom and IUD.

Table 5.2 Percent reporting use of method during last sexual intercourse and type of FP method used during last sex

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Used a method during last sex	76	60	45	51	72	50	61	48
Number of cases	145	124	46	61	90	53	102	92
Method used during last sex								
Pill	30	71	20	44	38	70	11	52
IUD	1	1	0	0	1	1	0	0
Injectables	1	8	6	23	1	6	2	14
Implant	1	0	0	0	0	0	0	1
Diaphragm	3	2	0	2	1	0	0	0
Male condom	63	17	76	29	58	23	88	33
Female condom	1	1	0	2	1	0	0	1
Tubal ligatomy	0	0	0	0	0	0	0	0
Vasectomy	0	0	0	0	0	0	0	0
Natural method	0	0	0	0	0	0	0	0
Number of cases	146	208	46	119	91	105	102	192

5.6 Reasons for use and non-use of method

Respondents were asked why they had or had not used a method during their last sexual intercourse. Table 5.3 shows that, among those who had used a method, females were much more likely to cite pregnancy prevention than males, except in Zone III where 67 percent of males gave this as a reason. Very few females used a method to prevent disease (0-11 percent), with males being more likely to give this reason (12-20 percent). Males were also more likely than females to cite a dual purpose (pregnancy and disease prevention.) This dual purpose was cited by 13 to 71 percent of males and by 14 to 27 percent of women.

As shown in Table 5.3, the two main reasons cited for not using a method during the last sexual intercourse were desire to get pregnant or unplanned sex ("sex just happened"). Except for males in Zone III, females were more likely than males to report desire to conceive as reason for not using a method during the last sexual intercourse.

Male respondents, on the other hand, were more likely than females to report that no method was used because "sex just happened". Other reasons mentioned for not using a method during the last sexual intercourse include perception of low risk to conceive or contract an STI. The percentage of women who reported that their partner refused to use a condom ranged from 11 to 17 percent in the four zones, whereas only 2 to 6 percent of males reported partner refusal. Respondent refusal to use a condom was reportedly very low, although 11 percent of males in Zone I said they refused.

Table 5.3 Percent distribution of reasons for using or not using a method during last sexual intercourse

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Reasons for using a method during last sex								
Prevent pregnancy	45	83	46	72	67	79	18	68
Prevent disease	12	3	20	11	20	0	12	4
Prevent pregnancy and disease	43	14	35	16	13	21	71	27
Number of cases	145	124	46	61	90	53	102	92
Reason for non-use of method during last sex								
Wanted pregnancy	26	36	4	31	60	24	5	28
Sex just happened	28	9	45	27	14	4	49	28
Partner refused condom	6	13	2	17	3	16	2	11
Self refused condom	11	2	4	0	3	0	3	2
Raped	0	1	0	0	0	2	0	0
Thought pregnancy risk was low	2	2	11	5	3	2	8	1
Thought disease risk was low	6	11	14	1	6	18	6	3
Other	21	25	21	17	11	35	29	27
Number of cases	47	85	56	58	35	51	66	100

5.7 When FP method was used last

Ever users and current users of contraceptive methods were asked when they had last used a method. Up to 10 percent of women in all zones had used a contraceptive method a month or less before the baseline study; between 7 and 32 percent had used a method between 1 and 3 months before the study while the majority, between 57 percent and 90 percent had used a method over three months before the study (see Table A5.1 in the Annex). For males, the majority had used a method over three months before the study.

5.8 Source of FP method used during last sexual intercourse

Ministry of Health and Child Welfare health facilities and CBDs were the most frequently reported sources of the last family planning method used (see Table A5.1 in the Annex).

Except for Zone IV, the comparison area, males (26 to 43 percent) were more likely than females (15 to 29 percent) to rely on CBDs as a source. Females in every zone were most likely to rely on MOH&CW health facilities (41 to 53 percent). As expected, facilities that are mostly located in urban areas, such as ZNFPC clinics, private facility/doctor and pharmacies, were the least frequently mentioned by these rural respondents. An exception was that 29 percent of males in the satellite area, which is fairly close to Bulawayo, got their last contraceptive supplies from pharmacies.

CHAPTER 6: KNOWLEDGE OF STIs / HIV / AIDS

The major objectives of expanding CBD roles are to improve STIs / HIV / AIDS knowledge of communities as a strategy to prevent the spread of HIV, improve the care of AIDS patients and promote the adoption of safer sexual behaviour. The baseline survey assessed the STIs / HIV / AIDS knowledge levels prior to the implementation of the pilot intervention.

6.1 Knowledge of STIs, including HIV

The majority of respondents in all zones (between 89 and 99 percent of respondents of both sexes in all zones) had ever heard of diseases that can be transmitted through sexual intercourse (see Table 6.1). Knowledge of HIV/AIDS was nearly universal across all four zones. Knowledge of other specific STIs was limited to gonorrhoea and syphilis, with more males having heard of different infections compared with women. Both sexes commonly mentioned "siki", which is a general word used for STIs. Except for a few respondents, both males and females interviewed know that there is no cure for AIDS.

Table 6.1 Percent distribution of respondents who have ever heard of STIs, type of STI known and percent who have ever heard of HIV / AIDS

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Ever heard of STIs	99	89	96	96	99	92	95	93
Number of cases	297	311	149	150	158	143	298	301
Ever heard of HIV/AIDS	100	99	99	97	100	99	100	101
Number of cases	300	311	149	150	158	143	298	301
STIs ever heard of:								
HIV/AIDS	96	96	93	96	99	98	93	94
Gonorrhoea	51	31	36	24	54	26	27	25
Syphillis	45	26	50	20	45	21	43	20
Chancroid	8	6	4	1	8	5	2	5
Chlamydia	1	1	1	0	0	2	1	1
Herpes	6	8	7	4	3	7	6	4
Other (mainly *siki*)	33	33	20	53	33	41	33	50
Number of cases	297	278	143	144	157	132	283	280

Note : *"siki"* means any kind of sexually transmitted infection

6.2 Knowledge of HIV modes of transmission

Having sex with a partner infected with HIV was the most frequently cited mode of HIV transmission with more males (64 to 87 percent) reporting the mode than females (53 to 70 percent) (see Table 6.2). Having multiple sexual partners was the second most frequently

mentioned mode of HIV transmission with women (25 to 52 percent) mentioning it more than males (10 to 33 percent) in all the four zones. Across all zones, only one to three percent knew about mother to child transmission.

Table 6.2 Percent distribution of respondents reporting knowledge of specific modes of HIV transmission

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Mode of transmission known:								
Having sex with infected partner	85	70	64	53	87	66	72	62
Multiple sexual partners	15	25	32	52	10	31	33	35
Having blood transfusion	7	8	7	3	2	5	9	10
Kissing on the mouth	3	3	0	2	3	1	0	3
Mother to baby during birth	1	1	3	3	1	1	1	2
Shaking hands	0	1	0	1	0	0	0	0
Mosquito bites	0	0	2	1	0	1	0	0
Witchcraft	0	0	0	1	0	0	0	0
Using condoms	0	0	0	1	0	0	0	0
Other	13	28	23	25	17	30	20	16
Number of cases	300	307	148	146	158	141	298	300

6.3 Main sources, and preferred source of HIV / AIDS information

In order to assess whether CBDs are disseminating HIV / AIDS information in their communities, respondents were asked to report their sources of such information (see Table A6.1 in the Annex). School was the most frequently mentioned source of HIV / AIDS information for both sexes in all the four zones, even for those who were no longer going to school. The radio was the second most frequently mentioned source, followed by friends / neighbours / relatives and the clinic. CBDs were mentioned as a source of HIV / AIDS information by less than five percent of respondents in all zones, regardless of gender (Table 6.3) hence a reflection of a gap that need to be addressed in the expanded CBD project .

Doctors and nurses were the preferred sources of information, although this varied by zone and gender. The percent that would prefer to get information on HIV/AIDS from the CBD is far higher than the percent that actually do so. This indicates that CBDs are valued and trusted, but that they generally do not discuss such issues with their clients who, in turn, do not consider them as good sources of such information. The expanded CBD pilot programme commenced

with training CBDs on HIV/AIDS so that they can be a source of accurate information for their clients.

Table 6.3 Percent distribution of respondents who have ever received HIV / AIDS information from CBDs and percent who prefer to receive HIV / AIDS information from CBDs

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Percent who received HIV/AIDS information from CBDs	2	2	1	1	4	2	0	1
Number of cases	300	307	148	146	158	141	298	300
Percent who prefer to get HIV/AIDS information from CBDs	30	20	12	9	21	23	9	13
Number of cases	299	311	149	150	157	143	149	301

CHAPTER 7: ATTITUDES AND PRACTICE RELATED TO HIV / AIDS

STI / HIV / AIDS programmes have been in place for a number of years as a strategy to encourage communities and individuals to be tested for HIV and practise responsible sexual behaviour. The expanded CBD roles include motivating clients to go for HIV tests at VCT centres. Respondents were asked whether they have ever been tested for HIV and reasons for going or for not being tested for HIV.

7.1 Self perception of risk of contracting HIV

Respondents were asked how they perceived their risk of contracting HIV (see Table A7.1 in the Annex). The largest proportion of respondents believed they were at no risk or low risk. Men (30-43 percent) were much more likely than women (8-26percent) to assess themselves as being at no risk. Women (36-47 percent) were most likely to say they were at low risk. Only five to twelve percent of men and women said they were at high risk.

Among those who thought they had no risk or low risk of contracting HIV, Zone III was different in that "only have one partner" was the most common reason they gave as to why they perceived their risk as nil or low. In the other zones, answers were distributed among several reasons, including "not yet sexually active", "abstaining from sex", "only have one partner" and "always use condoms." The two least common responses were "do not inject drugs" and "only have trustworthy partners." About half of males and females who reported that they were at no risk of getting HIV were not sexually experienced. One fifth of females considered themselves to be at medium to high risk of contracting HIV, and among this group, between 53 and 72 percent of females said that the reason was that they do not trust their partners. Men were slightly more likely to perceive themselves to be at either medium or high risk, and this group also cited not trusting partner as the main reason.

7.2 Percent ever tested for HIV and reasons for being tested or not tested

In Zone I, 13 percent of female respondents had been tested for HIV, but elsewhere this was less than 10 percent (see Table 7.1). However, at least two-thirds of respondents were willing to be tested, in order to know their status (change in behaviour was not cited as a reason). The main reason why respondents of both sexes were not willing to be tested for HIV was fear of a positive result, with large percentages also citing "no need for test." Thirty-two percent of males who felt there was no need for them to have an HIV test were sexually experienced - - 71 percent of these were still single, thus increasing their chance of having other pre-marital partners. Twenty-seven percent of females who felt there was no need for an HIV test were sexually experienced, including 32 percent who were still single.

Table 7.1 Percent distribution of respondents who have ever been tested for HIV. Percent willing to be tested for HIV and reasons for willingness or reluctance to be tested for HIV

HIV Testing	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Ever been tested	9	13	4	3	4	6	3	7
Willingness to be tested	78	81	64	69	82	78	66	79
Major reason willing to be tested is "just to know status"	100	95	98	98	100	92	100	99
Number of cases	299	307	148	146	158	141	298	300
Reasons for not willing to be tested:								
No need for test	45	39	44	44	38	36	45	45
Afraid of positive result	52	51	43	52	62	55	47	37
Afraid to be seen at VCT centre	0	5	0	0	0	3	1	2
Too expensive	0	5	7	4	0	7	1	16
Number of cases	65	59	54	46	29	31	102	62

7.3 Source of referral to HIV testing centre

Between 57 and 75 percent of females tested for VCT had been referred by doctors or nurses. Men, on the other hand, tended to be motivated by media such as radios and newspapers. Other cited sources of referral were school, friends/ neighbours / relatives, and the radio. An insignificant number cited referral to HIV testing centre by a CBD.

Table 7.2 Percent of respondents who got information on VCT sites from CBDs, percent who know specific place for HIV testing and percent referred to HIV testing center by CBDs

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Percent (%) who got information on VCT from CBDs	1	1	0	4	6	0	0	0
Number of cases	85	94	27	27	72	51	47	55
Knowledge of specific place for HIV testing	28	31	18	19	46	36	16	18
Number of cases	299	307	148	146	157	141	298	300
Ever been advised by CBD to go for HIV test	33	35	28	22	35	32	18	16
Percent (%) referred to VCT centre by CBDs	0	0	0	0	0	0	0	0
Number of cases	299	311	149	150	157	143	279	301

CHAPTER 8: EXPOSURE TO CBD SERVICES

The CBD Review Study showed that CBDs tended not to provide services to young unmarried members of the community despite increasing evidence that young people were becoming sexually experienced early and, in some instances, succumbing to HIV / AIDS. Reaching out to youth is a component of the expanded programme. Prior to the implementation of the pilot project, CBD training included skills for listening to and counseling young people, skills to conduct group talks, and a shift in focus to include more on RH / STIs / HIV / AIDS, in addition to family planning topics, during both one-to-one interactions and group talks.

8.1 Knowledge of community-based extension workers

The CBD is one of several extension workers who work in communities. Respondents were asked whether they knew the type of extension workers in their communities. Thirty three (33) percent of male respondents in the comparison areas were not aware of extension workers at community level. Table 8.1 shows that males are less likely to know about extension workers compared to their female counterparts. Table 8.1 further shows that the CBD was the most known extension worker, with between 73 percent and 79 percent males reporting knowledge of CBDs and between 48 and 85 percent female respondents doing the same.

Knowledge of the CBD name ranged between 44 and 67 percent for both male and female respondents. Village health workers were the second most frequently mentioned type of extension worker known to the respondents. It is important for communities to know their extension workers so that they get the required services. Extension workers need to coordinate their efforts hence the need for CBDs to attend extension workers' coordination meetings at village and ward levels so that other extension workers are aware of the expanded roles of CBDs and participate in the planning and implementation of HIV / AIDS-related activities. These findings also justify the need to inform communities of the new CBD roles through the planned advocacy and community mobilisation activities, thus generating demand for CBD services.

Table 8.1 Percent reporting knowledge of specific type of health workers who work at community level

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Type of extension worker known:								
None	11	9	21	19	5	11	33	22
ZNFPC CBD	79	83	76	49	79	85	73	48
Depot Holder	0	0	3	0	0	0	0	0
Village Health Worker	29	39	26	43	34	50	26	26
Peer Educator	2	1	0	3	0	0	0	0
Environmental Health Technician	2	4	2	2	0	1	4	3
Village Community Worker	2	15	14	13	5	1	9	23
Number of cases	306	311	149	150	157	143	279	301
Among those who know CBD or DH:								
Name of CBD known	50	63	52	62	67	64	44	54
Name of depot holder known	12	4	5	7	5	1	4	1
Number of cases	299	311	149	150	157	143	279	301

8.2 Knowledge of CBD / Depot Holder in the area

With the exception of women in Zone IV and Zone II, at least 75 percent of men and women knew about the ZNFPC CBD. These CBDs were much better known than any other kind of extension worker. Among those who knew about the CBD, half to two thirds could name her (with the exception of that only 44 percent of males in the comparison areas could do so.) (See Table 8.1.)

Prior to the implementation of the intervention, the family planning Depot Holder model was operational only in the Makoni District of Manicaland Province. Therefore, information on knowledge of depot holder was conducted simply to provide a baseline, and as expected, this is mainly zero. However, to provide a further probe, respondents who said they knew a CBD agent were also asked if they knew the name of the depot holder. The fact that one to twelve percent gave a name may indicate confusion between the ZNFPC programme and depot holders of chloroquine tablets.

8.3 Percent ever visited by CBDs and topics discussed

Despite high percentages knowing about the CBD, the percentages who had ever been visited by her were low. This ranged from 22 to 37 percent of female respondents and 12 to 39 percent of male respondents (Table 8.2). This is consistent with the CBD Review Study which found that CBDs are mainly engaged in re-supply of old clients, and that their catchment areas are too large. In the expanded programme, the catchment areas are reduced to ward level with an estimated population of 6,000.

CBDs in all zones tend to limit their discussion to family planning and STIs / HIV / AIDS. None of the respondents had ever discussed VCT with their local CBDs. In all the four zones, CBDs tend to discuss family planning-related issues more with females (ranging between 67 to 85 percent) and STI-related issues more with males (between 31 to 72 percent).

Table 8.2 Percent ever visited by CBDs and topics discussed during the CBD-client interaction

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Ever been visited by CBD	39	37	17	24	36	23	12	22
Number of cases	299	211	149	150	157	143	297	301
Issues discussed during CBD-client interaction:								
Family planning	50	82	63	83	78	67	53	85
HIV/AIDS	72	14	56	7	63	21	31	10
STIs	32	9	25	7	15	12	10	15
Home based care	1	0	0	0	2	8	20	0
VCT	0	0	0	0	0	0	0	0
Youth RH	0	1	6	7	0	6	0	0
Other RH	1	6	0	0	0	13	0	0
Number of cases	72	71	16	29	41	33	34	41

8.4 Exposure to group meetings addressed by CBDs

Although the current door-to-door CBD model emphasises interpersonal communication between CBDs and their clients, CBDs are also expected to periodically conduct group meetings within their catchment areas. Only three to ten percent of respondents had ever attended such meetings (Table 8.4). The same pattern was apparent during the 1991 and 1996 Situation Analysis studies. In the expanded programme, this aspect of CBD services has been included in the MIS as a strategy to increase the number of community meetings addressed by CBDs and to monitor the content of their group talks.

When group meetings are held, the topic is usually family planning. Between 58 and 85 percent of CBDs discussed family planning during their group meetings. HIV/AIDS and STIs were also discussed to a lesser extent, but more so with male respondents. The findings clearly confirm that CBDs generally do not discuss issues relating to home-based care, VCT, youth reproductive health issues. These topics have been included in the revised CBD curriculum and will be monitored during the pilot phase.

Table 8.4 Percent reporting ever attending group meetings addressed by CBDs and the content of the presentation

	Zone I		Zone 2		Zone 3		Zone 4	
	Depot Holder		Satellite		Depot Holder & Satellite		Comparison areas (old model)	
	M	F	M	F	M	F	M	F
Ever attended group meeting addressed by CBD	10	7	3	6	6	8	7	4
Number of cases	299	311	149	150	157	143	279	301
What CBD discussed during meeting:								
Family planning	71	74	80	78	67	58	75	85
HIV/AIDS	61	52	60	11	67	8	50	31
STIs	32	19	40	0	22	0	10	8
Home based care	3	0	0	0	0	8	20	0
VCT	0	0	0	0	0	0	0	0
Youth RH	0	1	0	7	0	6	0	0
Other RH	0	4	0	0	0	0	0	0
Number of cases	31	27	5	9	9	12	20	13

CHAPTER 9: CONCLUSIONS AND RECOMMENDATIONS

9.1 Monitoring and Evaluation

The baseline survey provided invaluable information for compiling baseline benchmarks, or indicators, relating to ZNFPC's Expanded CBD Programme objectives and to USAID's Intermediate Results in the area of HIV/AIDS prevention and mitigation. Programme success will be evaluated through quarterly monitoring of changes in these indicators, a midterm review and a final impact evaluation. The final evaluation will include a questionnaire similar to the one used in the baseline survey. Monitoring of changes in the baseline indicators will also be used to modify or adjust programme components as needed. Table A9.1 in the Appendix presents the full set of monitoring and evaluation indicators for the Expanded Programme.

A second baseline survey is planned for the fourth quarter of 2002, to capture information from the sites planned for the second phase of the expanded programme. The initial baseline questionnaire will need to be slightly revised to capture data identified as programme indicators in the October 2002 M&E Plan.

9.2 Background Characteristics and Implications for IEC

Most respondents have attended school and are literate in either Shona or Ndebele. Literacy in these languages is higher than literacy in English, so IEC efforts should be primarily in Shona and Ndebele. The high degree of literacy among youth means that IEC can be done through both audio and written media.

Since most of the respondents are students, homemakers, or engaged in miscellaneous income earning activities, and since many are still dependent on parental income, to reach the maximum number of youth, outreach activities need to be both school and community based.

9.3 Sexual practices of respondents and interactions with CBDs

Most of the 15-29 year olds surveyed in this baseline study were unmarried, but many had already experienced sexual intercourse. The never-married population may be especially vulnerable to unplanned pregnancy and sexually transmitted infections. Although targeting young unmarried women and men for reproductive health services is often socially unacceptable, the statistics on premarital sex, HIV infection and pregnancy indicate that this group is in need of reproductive health services. Only five to 16 percent of women were currently using male or female condoms (although 60 to 88 percent of men said that they were.) Almost three quarters of women said that they wanted to avoid pregnancy within the next twelve months, but only 50 to 67 percent were currently using contraception, indicating unmet need for family planning.

The survey confirmed other studies showing that high percentages of youth have already had sexual experience in adolescence, and that high percentages of sexual relationships are with non-spousal partners (girlfriends and boyfriends). While most respondents had only one sexual partner in the last year, fairly high percentages had more than one sexual partner. Although these sexual practices confirm that youth are at risk of contracting STIs, including HIV, an extremely small percentage of young women had discussed STIs, including HIV, with a CBD. CBDs tend to limit their discussions to family planning. At both group meetings and individual meetings, CBDs need to discuss safe sexual practices and risks of STIs and HIV with all clients, regardless of their gender. The level of discussion of issues such as home-based care, VCT and youth RH after the evaluation of the intervention will reflect on the impact of the CBD re-orientation and training prior to project intervention.

Schools, parents, CBDs and depot holders, in their interaction with young people, should encourage delayed sexual debut and abstinence, while at the same time recognizing the reality that adolescents need other information on safe sex, such as limiting the number of partners, correct and consistent use of condoms, and use of dual protection. The expanded programme plans to address these reproductive health needs through advocacy, community sensitization and mobilization and outreach specifically targeting vulnerable youth.

9.4 Knowledge and use of contraceptive and STI prevention methods

Very few men knew about methods other than the pill and the male condom, while both men and women were ill informed about methods available at clinics (especially permanent methods.) This lack of knowledge impedes shared responsibility for reproductive health related decisions, and in particular impedes use of dual protection. The expanded programme aims to encourage a shift to methods supplied at clinics, through referrals by CBDs. This will also require clinic-based service providers to be prepared to respond to increased demand for their services, such as the provision of injectables and other long-term methods. Linkages between ZNFPC and referral sites are important, and the ZNFPC Sister-in-Charge of community-based services should work with MOH&CW staff to ensure that supplies are always available at health facilities in the pilot sites.

The high percentages that knew about the CBD, and the number of clients getting contraceptives from CBDs, confirm that CBDs are in contact with members of the community who are sexually active. The fact that young men, who mainly reported condom use, got their last supplies from CBDs shows the role CBDs can play to motivate rural males for STIs/HIV/AIDS prevention. In the expanded programme, CBDs will have opportunities to discuss other RH issues, including HIV / AIDS, and referral for VCT, and to give advice to home-based care patients.

Many of the reasons for non-use of condom show that young men and women are naïve about risk. This is particularly true of young women who place their faith in partners' faithfulness, without considering previous sexual experience or the possibility of unfaithfulness. The percentages citing partner refusal to use condoms illustrate the need for CBDs to equip clients with skills to successfully negotiate condom use with their sexual partners. CBDs should also discuss the danger of unplanned sexual intercourse, and the need to be prepared with condoms, since this was another reason for non-use. Roughly one third of respondents believed they were

at low or no risk because they always use condoms. This is a target group for follow up to ensure that condoms use is consistent and correct.

Low percentages were practising dual protection, and improvement in this will be monitored in the expanded programme. Lastly, some self-reported high-risk youth are still not using condoms at all. Group meetings and other outreach activities should target these youth.

Almost all respondents indicated that they would like to be tested for HIV, in order "to know their status" yet VCT services are scarcely accessed by the surveyed rural youth. CBDs need to inform and motivate their communities and individual clients to go for VCT. Where possible, the CBD efforts to refer individuals for VCT should be complemented by other media at local level. Linkages should be strengthened between referral centres and the expanded programme, and the possibility of mobile or outreach VCT should be explored in order to lower access costs, since the high cost of transportation to urban areas with VCT services may be a discouraging factor for many. With or without testing, CBDs should stress the importance of safe sexual behaviours.

Concurrently with motivating youth to go for testing, CBDs need to educate individuals on how to live positively after testing positive to HIV, and clients families and communities need to be educated about accepting and caring for those who are living with HIV / AIDS.

APPENDIX

Table A4.1 Percent reporting specific sources of information on specific contraceptives

	Zone I Depot Holder		Zone II Satellite		Zone III Depot Holder & Satellite		Zone IV Comparison	
	M	F	M	F	M	F	M	F
Sources of information on oral contraceptives								
Doctor	9	38	7	42	20	51	5	40
CBD	18	17	12	42	20	9	6	10
Other Community Worker	1	1	3	1	4	4	0	1
Radio	7	5	11	1	3	2	9	1
Public meeting	1	1	1	2	1	0	0	1
School	30	20	9	13	22	1	25	17
Newspaper	1	0	3	1	3	0	1	1
Poster/Pamphlets	2	1	1	1	0	1	1	1
Friends	24	21	55	27	17	26	52	30
0thers	8	1	0	0	9	1 1	0	
No. of cases	274	282	121	150	154	139	224	285
Sources of information on IUD								
Doctor	6	37	13	53	15	45	6	50
CBD	4	10	0	2	7	6	4	3
Other Community Worker	1	1	6	2	2	0	0	1
Radio	12	6	15	1	21	6	10	1
Public meeting	1	2	2	4	0	0	0	1
School	52	22	15	15	24	14	44	26
Newspaper	10	1	11	1	14	0	0	1
Poster/Pamphlets	6	4	4	4	3	4	5	3
Friends	8	15	32	17	12	25	31	14
0thers	0	2	2	1	2	0	1	0
No. of cases	111	282	121	86	61	71	84	153

A4.1 Percent reporting specific sources of information on specific contraceptives (continued)

	Zone I Depot Holder		Zone II Satellite		Zone III Depot Holder & Satellite		Zone IV Comparison	
	M	F	M	F	M	F	M	F
Sources of information on injectables								
Doctor	14	47	8	51	44	55	7	48
CBD	10	10	8	5	6	4	3	5
Other Community Worker	0	1	5	2	1	1	1	1
Radio	15	3	12	1	11	2	9	1
Public meeting	2	1	2	3	1	0	1	7
School	22	13	10	9	15	1	23	17
Newspaper	1	0	2	2	1	0	2	1
Poster/Pamphlets	3	1	4	0	2	0	2	1
Friends	31	23	48	27	17	35	53	27
0thers	2	1	2	0	4	0	0	0
No. of cases	283	282	147	150	152	139	224	289
Sources of information on Norplant								
Doctor	9	42	14	50	35	56	0	49
CBD	3	6	0	0	6	3	4	8
Other Community Worker	9	0	0	7	0	3	0	2
Radio	6	11	7	4	35	9	17	3
Public meeting	6	0	0	9	6	0	0	2
School	38	11	14	13	0	3	35	14
Newspaper	6	0	14	0	6	0	4	0
Poster/Pamphlets	9	0	0	4	0	4	9	0
Friends	24	24	50	13	12	25	30	6
0thers	0	6	0	0	0	0	0	16
No. of cases	71	34	14	46	17	32	23	63
Sources of information on male condom								
Doctor	5	24	5	34	10	32	5	34
CBD	12	11	7	5	6	12	4	6
Other Community Worker	1	2	1	3	2	5	1	1
Radio	12	11	10	3	13	9	8	7
Public meeting	3	3	0	3	3	1	1	1
School	40	22	11	15	50	13	28	22
Newspaper	1	0	1	0	0	2	1	0
Poster/Pamphlets	1	1	1	2	1	1	1	2

Friends/neighbours/ relatives	27	21	64	36	15	22	52	31
0thers	0	6	0	0	0	4	0	1
No. of cases	294	275	140	131	158	120	289	268

A4.1 Percent reporting specific sources of information on specific contraceptives (continued)

	Zone I Depot Holder		Zone II Satellite		Zone III Depot Holder & Satellite		Zone IV Comparison	
	M	F	M	F	M	F	M	F
Sources of information on female condom								
Doctor	7	22	4	37	19	31	5	36
CBD	9	10	5	2	7	5	1	6
Other Community Worker	1	2	3	5	1	0	0	1
Radio	25	17	18	4	18	23	14	5
Public meeting	3	4	0	4	2	1	1	1
School	21	20	6	13	12	9	23	24
Newspaper	5	0	1	0	4	0	1	2
Poster/Pamphlets	6	1	0	2	9	2	2	3
Friends/neighbours/relatives	23	20	56	32	26	16	53	23
0thers	0	5	5	0	2	0	1	1
No. of cases	219	214	93	97	133	87	175	189
Sources of information on tubal ligation								
Doctor/Nurse/Clinic	12	36	9	38	23	47	4	43
CBD	3	7	0	3	7	3	1	2
Other Community Worker	0	0	4	3	1	0	0	1
Radio	14	8	21	6	13	5	7	2
Public meeting	1	2	0	4	2	0	0	0
School	33	14	15	15	18	3	33	22
Newspaper/magazine	3	0	0	0	4	0	0	0
Poster/pamphlets	3	1	8	1	5	0	3	2
Friends/neighbours/relatives	31	29	43	30	25	39	52	29
Other	1	4	0	0	2	4	0	0
No. of cases	156	168	53	79	100	78	111	108

A4.1 Percent reporting specific sources of information on specific contraceptives (continued)

	Zone I Depot Holder		Zone II Satellite		Zone III Depot Holder & Satellite		Zone IV Comparison	
	M	F	M	F	M	F	M	F
Sources of information on periodic abstinence								
Doctor/Nurse/Clinic	3	11	3	17	4	27	2	11
CBD	1	0	0	3	2	0	0	2
Other Community Worker	0	1	0	0	0	3	0	0
Radio	1	1	0	3	2	3	2	4
Public meeting	0	1	0	0	0	0	0	2
School	52	46	14	43	32	34	51	58
Newspaper/magazine	1	1	3	3	1	2	0	0
Poster/pamphlets	1	1	5	0	1	0	3	2
Friends/neighbours/relative	29	3	70	26	23	29	42	23
Other	14	2	5	6	35	2	1	0
No. of cases	192	106	37	37	102	59	112	57
Sources of information on vasectomy								
Doctor/Nurse/Clinic	6	29	6	44	20	63	2	38
CBD	3	5	0	2	6	3	1	2
Other Community Worker	0	1	4	7	1	0	0	2
Radio	11	10	20	9	10	5	8	3
Public meeting	2	1	0	5	1	3	0	2
School	47	29	18	19	30	3	54	39
Newspaper/magazine	3	0	0	0	4	5	1	0
Poster/pamphlets	6	2	10	0	6	5	3	2
Friends/neighbours/relatives	22	21	41	14	23	13	31	13
Other	0	2	2	0	0	0	0	0
No. of cases	116	97	51	43	71	38	88	61

Table A4.2 Percent reporting specific method source for current contraceptive method

	Zone I Depot Holder		Zone II Satellite		Zone III Depot Holder & Satellite		Zone IV Comparison	
	M	F	M	F	M	F	M	F
Current method source								
ZNFPC Clinic	5	8	4	4	5	29	4	0
MOH&CW clinic	36	37	36	75	29	41	35	58
Private facility/Doctor	0	1	4	2	0	0	0	2
CBD	44	51	33	15	53	29	29	28
Other Community Health Worker	1	0	2	4	12	2	1	2
Pharmacy	15	2	22	0	1	0	32	7
No. of cases	110	107	55	52	77	49	84	57

Table A5.1 Percent reporting when method was last used and specific source of method

	Zone I Depot Holder		Zone II Satellite		Zone III Depot Holder & Satellite		Zone IV Comparison	
	M	F	M	F	M	F	M	F
When FP method was last used by area type								
Less than one month ago	4	9	29	10	17	7	32	3
1 to 3 months ago	11	32	35	17	6	13	8	7
More than 3 months ago	83	57	29	73	72	77	50	90
Can't remember	2	2	6	0	6	3	10	0
No. of cases	53	53	17	30	36	30	50	58
Specific source of last FP method by area type								
ZNFPC Clinic	6	23	6	3	11	23	4	2
MOH&CW clinic	26	51	29	53	31	41	40	53
Private facility/Doctor	4	2	0	3	8	0	0	3
CBD	43	15	35	20	44	17	26	29
Other Community Health Worker	2	0	0	3	6	3	12	3
Pharmacy	15	2	29	7	0	3	16	5
No. of cases	53	53	17	30	36	30	50	58

Table A6.1 Percent reporting specific source of HIV / AIDS information

	Zone I Depot Holder		**Zone II** Satellite		**Zone III** Depot Holder & Satellite		**Zone IV** Comparison	
	M	F	M	F	M	F	M	F
Doctor/Nurse/Clinic	5	21	1	24	3	29	3	28
CBD	2	2	1	1	4	2	0	1
Other Community Worker	2	2	1	1	0	1	0	1
Radio	17	16	14	14	27	16	20	8
Public meeting	5	6	1	7	6	3	1	4
School	45	28	19	28	41	31	37	35
Newspaper/magazine	3	4	7	5	4	1	2	4
Poster/pamphlets	2	2	3	2	3	1	3	4
Friends/neighbours/relative	17	14	45	12	12	14	31	14
Other	2	5	10	6	0	2	3	1
No. of cases	300	307	148	146	158	141	298	300

Table A6.2 Percent reporting specific preferred source of HIV / AIDS information

	Zone I Depot Holder		**Zone II** Satellite		**Zone III** Depot Holder & Satellite		**Zone IV** Comparison	
	M	F	M	F	M	F	M	F
Doctor	31	19	46	18	45	8	42	20
Nurse at ZNFPC Clinic	5	8	13	7	8	26	7	4
Nurse at Health facility	15	33	14	47	22	22	23	49
CBD	30	20	12	9	21	23	9	13
Depot Holder	4	8	3	6	1	8	2	5
Village Health Worker	0	0	11	13	0	0	5	7
Other people	14	12	0	0	4	13	12	4
No. of cases	299	311	149	150	157	143	149	301

Table A7.1 Percent reporting level of perceived risk to contract HIV

	Zone I Depot Holder		Zone II Satellite		Zone III Depot Holder & Satellite		Zone IV Comparison	
	M	F	M	F	M	F	M	F
Self perception of risk to contract HIV/AIDS								
No risk	43	14	30	8	37	26	42	10
Low risk	18	44	25	43	35	36	18	47
Medium risk	18	16	17	14	18	16	11	12
High risk	9	5	12	11	7	8	10	10
Don't know	11	21	16	25	3	14	22	21
No. of cases	29	306	148	146	158	141	297	300

Table A7.2 Percent reporting specific reason for perceived risk to contract HIV

	Zone I Depot Holder		Zone II Satellite		Zone III Depot Holder & Satellite		Zone IV Comparison	
	M	F	M	F	M	F	M	F
Reasons for perceiving low or no risk of contracting HIV								
Not yet sexually active	22	30	21	15	12	24	35	39
Abstains from sex	19	21	18	23	15	15	14	20
Only has one partner	27	25	21	7	40	44	19	11
Always uses condoms	26	3	11	30	29	5	17	8
Does not inject drugs	1	2	10	4	0	0	1	2
Only has trustworthy partners	3	10	16	12	4	1	11	9
No. of cases	18	177	82	74	114	88	179	171
Reason for perceiving medium or high risk of contracting HIV								
Has more than one partner	14	3	7	3	23	0	11	3
Has many boy/girlfriends	31	0	2	8	33	3	9	5
Does not use condoms	5	5	12	11	13	0	6	3
Partner has multiple partners	5	5	2	14	5	9	4	2
Does not trust partners	32	62	49	53	23	68	57	72
Injection drugs	4	2	0	0	0	0	0	0
No. of cases	81	65	43	36	39	34	54	67

Table A7.3 Percent reporting specific source of referral to HIV testing center visited

	Zone I Depot Holder		**Zone II** Satellite		**Zone III** Depot Holder & Satellite		**Zone IV** Comparison	
	M	F	M	F	M	F	M	F
Referred by Doctor/Nurse	15	67	33	75	29	68	33	57
Referred by CBD	0	0	0	0	0	0	0	0
Referred by Clinic Health Worker	0	5	0	0	0	0	0	5
Newspaper	4	0	0	0	0	0	0	0
Radio	15	10	17	0	14	0	0	0
Friend/neighbour / relatives	4	8	17	25	43	11	44	0
School	19	3	17	0	14	0	0	33
Other	44	8	17	0	0	0	22	0
No. of cases	27	39	6	4	7	9	9	21

Table A7.4 Percent reporting specific source of information on VCT sites

	Zone I Depot Holder		**Zone II** Satellite		**Zone III** Depot Holder & Satellite		**Zone IV** Comparison	
	M	F	M	F	M	F	M	F
Doctor/Nurse/Clinic	9	32	7	30	8	33	34	20
CBD	1	1	0	4	6	0	0	0
Other Community Worker	0	4	0	4	0	0	0	2
Radio	46	31	37	37	47	24	23	24
Public meeting	5	2	0	0	1	0	0	2
School	5	6	4	0	13	6	0	6
Newspaper/magazine	6	1	7	0	4	0	0	2
Poster/pamphlets	0	0	4	4	6	2	0	0
Friends/neighbours/relatives	22	12	26	7	14	20	36	31
Rumours/Gossip	0	1	1	0	0	0	0	0
Other	2	10	15	15	1	16	6	15
No. of cases	85	94	27	27	72	51	47	55

Table A7.5 Percent reporting availability of cure of AIDS

	Zone I Depot Holder		Zone II Satellite		Zone III Depot Holder & Satellite		Zone IV Comparison	
	M	F	M	F	M	F	M	F
Knowledge of a cure for AIDS	3	1	2	0	1	4	1	2
No. of cases	399	307	148	146	157	141	298	300

Table A9.1 Monitoring and evaluation indicators for the Expanded CBD Programme

Key:
Indicators in bold: key indicators of programme performance
Column 1: IRs
The first column (IRs) shows the Intermediates Results to which each indicator is related. We also include in this column the referral number of the sub agreement indicators, which are described in the preceding paragraph;
ZIR: Zimbabwe/USAID Intermediate result followed by the correspondent number (ZIR1) Behavior change resulting from increased use of quality services with proven effectiveness to prevent HIV transmission and mitigate impact at household level.
A or B: Sub agreement indicators followed by the related number of the indicators (ie: B1. stands for proportion of key client groups practicing contraception)
AIR: Advance Africa Intermediate Result (AIR1 stands for Increased access to and improved quality of FP/RH clinical and non-clinical programs

IRs	Indicators	Data Sources	Methods of Collection	Frequency and schedules of data collection	Baseline	EOP Target	Indicators level
ZIR1 A1 AIR1	The percentage of CBDs in the new program performing in accordance with norms and standards	Supervision report	Supervision and checklist. Responsible SICC	Quarterly	No Data System need to be settled after discussion with service delivery	15 to 25% increased according to index	output
ZIR1 A1 AIR1	The percentage of Group Leaders in the new program	Supervision report	Supervision	Quarterly	No Data System need to be	15 to 25% increased	output

IRs	Indicators	Data Sources	Methods of Collection	Frequency and schedules of data collection	Baseline	EOP Target	Indicators level
	performing in accordance with norms and standards				settled after discussion with service delivery	according to index	
ZIR1 A1 AIR1	# of CBD, group leaders trained	Training Unit Management	Training reports	Yearly		[include the number to be trained]	output
ZIR1 A2 AIR1	The percentage of adult males referred for HIV/AIDS/STI, referrals CBD	MIS referral summary	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of adult females referred for HIV/AIDS/STI, referrals by CBD	MIS referral summary	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of male youths referred for HIV/AIDS/STI, referrals by CBD	MIS referral summary form code 14	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of female youths referred for HIV/AIDS/STI, referrals by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of clients referred for HIV/AIDS/STI, referrals by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of adult females referred for PAC services by CBD	MIS referral summary form code 10	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of young females referred for PAC services by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of adult males referred for VCT services by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of adult females referred for VCT services by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output

IRs	Indicators	Data Sources	Methods of Collection	Frequency and schedules of data collection	Baseline	EOP Target	Indicators level
ZIR1 A2 AIR1	The percentage of male youths referred for VCT services by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of female youths referred for VCT services by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of clients referred for VCT, by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A2 AIR1	# of VCT adult female clients from CBD referral system	MIS referral summary form (partnership with PSI)	Referral system	Six months	No data	25 to 50% increase	output
ZIR1 A2 AIR1	# of VCT adult male clients from CBD referral system	MIS referral summary form (partnership with PSI	Referral system	Six months	No data	25 to 50% increase	output
ZIR1 A2 AIR1	# of VCT young male clients from CBD referral system	MIS referral summary form (partnership with PSI	Referral system	Six months	No data	25 to 50% increase	output
ZIR1 A2 AIR1	# of VCT young females clients from CBD referral system	MIS referral summary form (partnership with PSI)	Referral system	Six months	No data	25 to 50% increase	output
ZIR1 A2 AIR1	# of VCT clients from CBD referral system	MIS Referral summary form (partnership with PSI	Referral system	Six months	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of VCT clients from CBD referral system	MIS Referral summary form (partnership with PSI)	Referral system	Six months	No data	25 to 50% increase	output
ZIR1 A2 AIR1	The percentage of adult males referred for FP by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output

IRs	Indicators	Data Sources	Methods of Collection	Frequency and schedules of data collection	Baseline	EOP Target	Indicators level
ZIR1 A2 AIR1	The percentage of adult females referred for FP (Injectable, IUD, Implant, TL) by CBD	MIS referral summary form	Referral system	Quarterly	No data	25 to 50% increase	output
ZIR1 A3 AIR1	Percentage of CBDs with stock levels above 4 months	Logistic system	Data collection from the logistic system	Quarterly	No data	75% of CBD with stock level above 4 months	output
ZIR1 A3 AIR1	Percentage of DHs with stock levels above 4 months	Logistic system	Data collection from the logistic system	Quarterly	No data	75% of CBD with stock level above 4 months	output
ZIR1 A3 AIR1	Percentage of CBDs that experience a stock out during the quarter	Logistic system	Monthly stock monitoring report	Quarterly	No data	Less than 25 %	output
ZIR1 A3 AIR1	The percentage of CBDs regularly submitting quarterly logistical/order forms for contraceptives	Logistic system	Logistic order form	Quarterly	No data	75% of CBD submitting quarterly logistical order forms	output
ZIR1 A3 AIR1	The percentage of CBDs regularly submitting quarterly order forms for IEC materials	Supervision report	Minutes reports	Quarterly	No data	75% of CBD submitting quarterly IEC materials forms	output
ZIR1 A4 AIR1	The percentage of CBDs attending VIDCO meetings in which program activities are coordinated with other FP/HIV/AIDS services organizations	Minutes	Minutes reports	6 months	No data	80% of CBD attending VIDCO coordination meetings	input

IRs	Indicators	Data Sources	Methods of Collection	Frequency and schedules of data collection	Baseline	EOP Target	Indicators level
ZIR1 A4 AIR1	The percentage of CBDs attending WADCO meetings in which program activities are coordinated with other FP/HIV/AIDS services organizations	Minutes	Minutes reports	6 months	No data	80% of CBD attending WADCO coordination meeting	input
ZIR1 A4 AIR1	The percentage of CBDs attending Ward health team meetings in which program activities are coordinated with other FP/HIV/AIDS services organizations	Minutes	Minutes reports	6 months	No data	80% OF CBD attending ward health meeting	input
IRI B4 AIR2	Number of group talks done by CBDs with young people	MIS	Group talk form	Quarterly	No data	[include the expected number]	output
ZIR1 B4 AIR2	Number of group talks done by CBDs with adult people	MIS	Group talk form	Quarterly	No data	[include the expected number]	output
ZIR1 B4 AIR2	Number of male youths attending group meetings	MIS	Group talk form	Quarterly	No data	[include the expected number]	output
ZIR1 B4 AIR2	Number of female youths attending group meetings	MIS	Group talk form	Quarterly	No data	[include the expected number]	output
ZIR1 B4 AIR2	Number of home based care clients visited	MIS	Home based care form.	Quarterly	No data	[include the expected number]	output
ZIR1 B4 AIR2	# of trainers trained in the new aspects/ role of the expanded program	Training unit documentation	Training report	Quarterly	0	[include the expected number]	output
ZIR1 B4 AIR2	# of provincial managers trained in the new aspects/ role of the expanded program	Training unit documentation	Training report	Quarterly	0	[include the expected number]	output

IRs	Indicators	Data Sources	Methods of Collection	Frequency and schedules of data collection	Baseline	EOP Target	Indicators level
ZIR1 B4 AIR2	# of CBD trained the new aspects / role of the expanded program	Training unit documentation	Training report	Quarterly	0	[include the expected number]	output
ZIR1 B4 AIR2	# of DH trained in the new aspects / role of the expanded program	Training unit documentation	Training report	Quarterly	0	[include the expected number]	output
ZIR1 B4 AIR2	# of CBD/DH who passed test first time	Training unit documentation	Training report	Quarterly	0	[include the expected number]	output
ZIR1 B4 AIR2	# of training follow up visits for on the job corrections	Training unit documentation	Training report	Quarterly	0	[include the expected number]	output
ZIR1 B4 AIR2	# of CBD/depots holder distributing the pamphlets for youth	IEC unit documentation	Training report	Quarterly	0	[include the expected number]	output
ZIR1 B4 AIR2	# of social mobilization meetings organized by CBD/DH	IEC unit documentation	Training report	Quarterly	0	[include the expected number]	output
ZIR1 B1 AIR1	# Condoms distributed	MIS	Service statistics	Quarterly	January-march 2002 130112	15 to 25% increase	output
ZIR1 B1 AIR1	# Of CYP	MIS	Service statistics	Quarterly	January-march 2002 3346	15 to 25 % increase	Output
ZIR1 A1 AIR2	% of male aged 15 to 29 advised by CBD to go for an HIV test	Survey	Baseline and endline	3 years	8.5%	11%	outcome
ZIR1 A1 AIR2	% of female aged 15 to 29 advised by CBD to go for an HIV test	Survey	Baseline and endline	3 Years	22%	32%	outcome
ZIR1 A1 AIR2	% of males aged 15 to 29 attending meeting addressed by CBD	Survey	Baseline and endline	3 Years	10.6 %	25%	outcome
ZIR1 A1 AIR2	% of females aged 15 to 29 attending meeting addressed by CBD	Survey	Baseline and endline	3 Years	7%	10%	outcome

IRs	Indicators	Data Sources	Methods of Collection	Frequency and schedules of data collection	Baseline	EOP Target	Indicators level
ZIR1 A1 AIR2	% of male aged 15 to 29 using method for dual protection (prevent both disease and pregnancy)	Survey	Baseline and endline survey	3 Years	21.3%	50%	outcome
ZIR1 A1 AIR2	% of females aged 15 to 29 using method for dual protection (prevent both disease and pregnancy)	Survey	Baseline and endline survey	3 Years	9%	20%	outcome
ZIR1 A1 AIR2	% of males aged 15 to 29 having casual sexual partners (stranger, just met or occasional partner)	Survey	Baseline and end line survey	3 Years	5%	3%	outcome
ZIR1 A1 AIR2	% of females aged 15 to 29 having casual sexual partners (stranger, just met or occasional partner)	Survey	Baseline and end line survey	3 Years	1%	Less than 1%	outcome
ZIR1 A1 AIR2	% of male aged 15 to 29 having more than one sexual partners during the last 12 months	Survey	Baseline and end line survey	3 Years	40.5%	30%	outcome
ZIR1 A1 AIR2	% of males aged 15 to 29 using male condoms during the last sexual intercourse	Survey	Baseline and end line survey	3 Years	42.6%	55%	Outcome
ZIR1 A1 AIR2	% of females aged 15 to 29 using females condoms during the last sexual intercourse	Survey	Baseline and end line survey	3 Years	15.5%	30%	Outcome
ZIR1 A1 AIR2	% of males aged 15 to 29 practicing contraception	Survey	Baseline and end line	3 years	74 %	5 to 10 % increase	outcome
ZIR1 B2 AIR1	% of females aged 15 to 29 practicing contraception during the survey period	Survey	Baseline and end line	3 years	64.8%	5 to 10 % increase	outcome